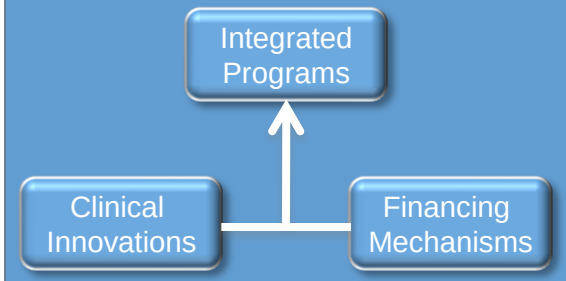
Health Care Innovations in Maryland



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MARYLAND

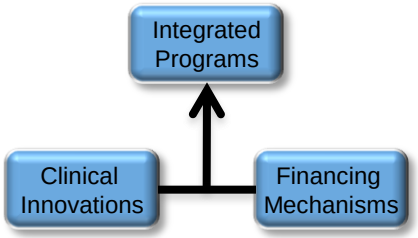
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Welcome

In this time of rising health care costs and tight budgets, Maryland's consumers, hospitals, clinicians, insurance plans and community groups are working together to develop creative programs that enhance patient **care**, improve population **health** and cut **cost**s.

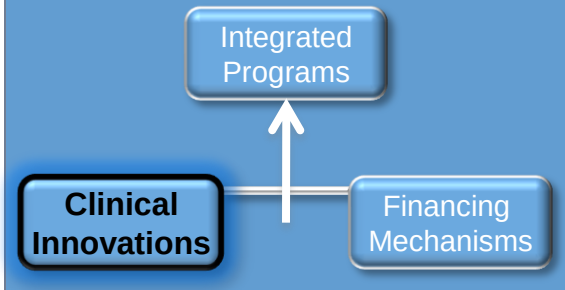
About the database:

The health care projects featured in this database are already delivering care in the state of Maryland. Search below to learn more about the future of Maryland's health care, and some of the innovative tools that will get us there.






Health Care Innovations in Maryland



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Clinical Innovations

Better health for Marylanders requires innovative community strategies that prevent illness, complications, and reduce health care cost through approaches to supporting patients. Click on the approaches below for more information and to see who is seeking to achieve these goals .

Community-Based Chronic Disease Management

Electronic Medical Record Networks

Evidence-Based Clinical Practice Support

Health Information Exchanges

Home Health Support Services

Integrated Hospice Care

Integrated Primary, Mental and Behavioral health care

Intensive Case Management

Maximized Support Network for High-Risk Patients

Patient Centered Medical Homes

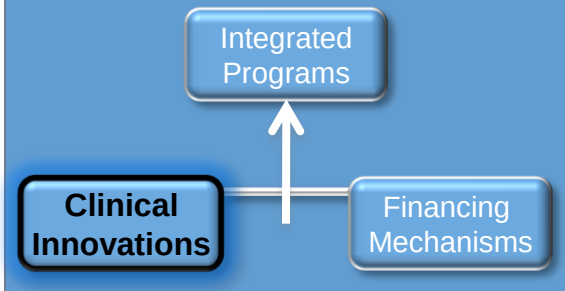
Patient Navigation from ED to Primary Care

Post-Discharge Care Transitions Program

Remote Monitoring

Telemedicine

Health Care Innovations in Maryland



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Clinical Innovations

Patient-Centered Medical Home

A Patient-Centered Medical Home is a team-based model of care that provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH team typically consists of physicians, nurse practitioners, nurses, social workers, nutritionists, and other allied health professionals working together to provide preventive services, treatment of acute and chronic illness, and social support.

Here are some of the Maryland providers putting the PCMH model into use. Click on the links for more information:

Stand-Alone Medical Home Projects:

Maryland Medical Home Plus Project

The Memory and Alzheimer's Treatment Center

The Sickle Cell Infusion Center

Integrated Medical Home Projects with Supportive Financing:

Maryland Multi-Payer Patient-Centered Medical Home

CareFirst Primary Care Medical Homes Program

Adventist Patient-Centered Medical Home Pilot

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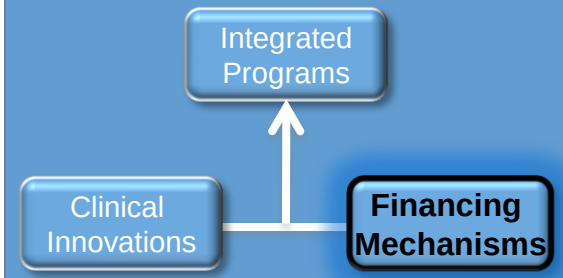

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Financing Better Health

Restructuring the way we pay for care plays an important role in promoting the kind of preventive and coordinated care that keeps patients healthy. These approaches to paying for care support better outcomes at lower cost.

Bundled Payments

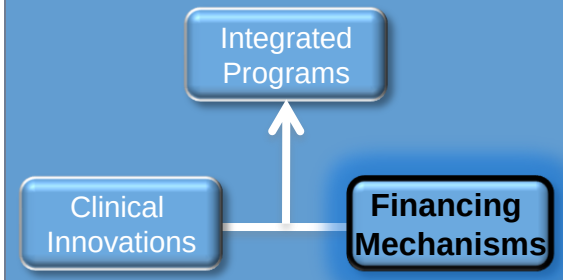
Global Budgets

Incentives for Reducing Preventable Hospital Readmissions

Shared Savings

Self-Insurance

Health Care Innovations in Maryland



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Financing Better Health

Maryland Total Patient Revenue

What They're Doing: Global Budgets that cover all inpatient and outpatient services provided by participating rural hospitals with protections against reductions in volume

Financing Mechanism: Total Patient Revenue is a three-year pilot program to test a voluntary alternative healthcare financing program for rural hospitals run by the Maryland Health Services Cost Review Commission (HSCRC). Participating hospitals receive a global budget that covers all inpatient and outpatient services provided by the hospital. The payment is calculated based on the hospital's charges from the prior fiscal year's with an annual rate update that is adjusted for performance on specific quality (both process and outcome) measures. This budget is used to determine the rate that the hospital can charge Medicare, Medicaid and private insurers for each service. If the hospital can increase efficiency, control costs or reduce avoidable ED visits, admissions and readmissions, it gets to keep 100% of the savings. If the costs increase beyond the allotted amount, then the hospital bears the financial risk. However, there is protection for hospitals to ensure that they do not lose revenue if volume decreases.

Evaluation Plan: HSCRC will review the number of hospital readmissions and how hospitals score on various quality (both outcome and process measure) before and after the program. Additionally, hospitals must submit any clinical innovations implemented in response to the program to the HSCRC.

Outcomes: Not available at this time. Pilot results expected end of 2013.

Target Population: Rural Hospitals in Maryland (10 hospitals currently participating)

Date of Implementation: July 2010
Contact: Steve Ports at the Maryland Health Services Cost Review Commission (HSCRC) sports@hscrc.state.md.us.
Multimedia: pending
Where to learn more: pending

Learn how Maryland hospitals are implementing Clinical innovations with support from Total Patient Revenue below:

Calvert Memorial Hospital

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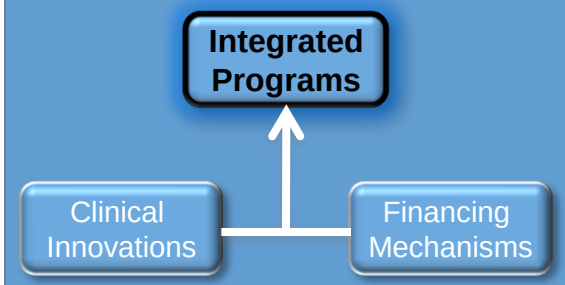

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Integrated Programs

Organizations across Maryland are combining clinical innovations with supportive financing to meet the goals of the Triple Aim: enhancement of patient care, improvement of population health and reduction of cost.

Click on the examples below to learn more about how these programs mobilize cost-saving financial mechanisms to improve care:

Adventist Patient-Centered Medical Home Pilot

Medical Home for High-Risk Patients supported by Self-Insuring

CareFirst Primary Care Medical Homes Program

Medical Home project supported by Enhanced Provider Fee Rates, Provider Incentives for Coordinated Care and Shared Savings

Johns Hopkins ElderPlus

All-Inclusive Care supported by Global Budgets

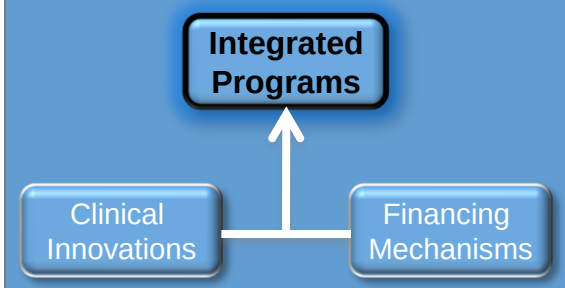
Maryland Multi-Payer Patient-Centered Medical Home

Medical Home Project supported by Shared Savings

Shore Wellness Partners

Intensive Case management supported by Total Patient Revenue

Health Care Innovations in Maryland



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Integrated Programs

Maryland Multi-Payor Patient-Centered Medical Home

What They're Doing: State-wide Medical Home initiative supported by Shared Savings

Clinical Innovation: Creation of Maryland Learning Collaborative to support primary care practices in their transformation into Patient-Centered Medical Homes. These practice models emphasize integrated care coordination teams and individualized care plans, offering a uniquely flexible and responsive care centers for patients, and featuring 24/7 phone access, same-day appointments, and email communication options.

Financing Mechanism: Maryland law requires the five major insurance carriers and Medicaid to participate, and several other public employee plans have voluntarily joined in. Each practice enrolled in the program receives a transformation loan to finance costs associated with technology adaptation to moving to the medical home structure of care. A standard fee-for-service model per payer applies thereafter, with an annual reconciliation process where current year costs are compared to historical baseline and savings are shared equally between the plan and provider.

Evaluation Plan: Evaluation will be conducted by a third party and will focus on measures of quality, cost, patient/provider satisfaction surveys, and impact on health disparities.

Outcomes: No results available at this time.

Target Population: Currently 53 practices participating from across the state.

Date of Implementation: Learning collaboratives launched May 2011, practices operational July 2011.
Contact: Susan Myers
Multimedia: pending
Where to learn more: http://mhcc.maryland.gov/pcmh

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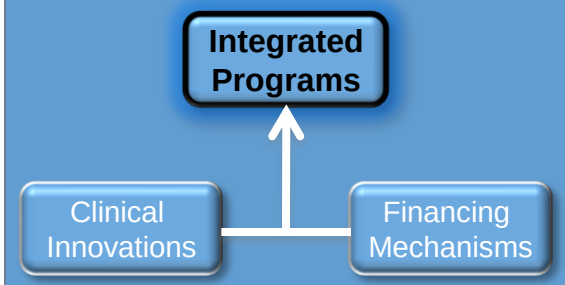

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Integrated Programs

Johns Hopkins ElderPlus

Program of All-Inclusive Care for the Elderly

What They're Doing: All-Inclusive Care supported by Global Budgets

Clinical Innovation: All-inclusive coordination of preventive, primary, acute, and long-term care services for a nursing home-eligible population, allowing them to remain living independently while maximizing support services and reducing the need for hospitalization.

Financing Mechanism: Global payment system where Medicare and Medicaid provide risk-adjusted up-front monthly payments for each patient, incentivizing wellness promotion, prevention, and avoidance of unnecessary hospitalization.

Outcomes:

- ✓A rate of hospitalization equal to that of the general Medicare population, despite a sicker nursing home-eligible population at baseline.
- ✓96% of patients are able to remain living independently
- ✓95% of participants would recommend the program to a family member or friend

Target Population: High-risk nursing home-eligible elderly population living at home.

Date of Implementation: January 1996

Contact: Nicki McCann, nmccann4@jhu.edu

Multimedia: Pending

Where to learn more: www.hopkinsbayview.org/hopkinselderplus